STATE OF OKLAHOMA
Oklahoma Health Care Authority
4545 N. Lincoln Blvd., Suite 124
Oklahoma City, OK 73105 (405) 522-7300

Authorization to Release Medicaid Records

Client Name:_____ **Client ID#:**_____ **DOB:**_____

1. I authorize the OHCA to release the above individual's Medicaid information as described below.

2. I understand the information in my Medicaid record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

3. This information may be released to the following:

Name: _____

Address: _____

Phone: _____ FAX: _____

4. For the purpose of:

5. I understand that I can change this authorization at any time. I understand that I must change this authorization in writing to OHCA. I understand that information may have already been released based on this authorization. Unless changed, this authorization will expire on the following date:_____. If I don't put a date, this authorization will expire in six months.

6. I understand that signing this release is voluntary, and a refusal to sign does not affect my receipt of Medicaid services. I may inspect or obtain a copy of the information to be released.

Under penalty of law, I represent that I am, in fact, the undersigned, or his/her legal representative.

Signature of Patient or Legal Representative *(Legal representative must show relationship to patient):*

X _____ Date: _____

Relationship to patient: _____

Signature of Witness

X _____ Date: _____